MEDICAL INSURANCE FORM

Complete this form only if the children involved in this action are applying for or receiving AFDC or Medi-Cal. Send to the Department of Health Services once the noncustodial parent health insurance coverage for the dependent child(ren) is obtained and verified.

Mail to: Department of Health Services
Other Coverage Section, #964
P.O. Box 1287
Sacramento, CA 95812-1287

FOR COUNTY USE ONLY

Date: _____

PLEASE TYPE OR PRINT (**DO NOT** ABBREVIATE)

COUNTY INFORMATION (ITEMS 1 THROUGH 3)

1. County	2. IV-D case number	3. Phone number ( )

CUSTODIAL PARENT INFORMATION (ITEMS 4 THROUGH 10)

4. Name (first)	(middle)	(last)	5. Social Security number
6. Complete street address			
City	State	ZIP code	7. Home telephone number ( )
8. Name of employer			
9. Employer's complete street address			
City	State	ZIP code	10. Work telephone number ( )

DEPENDENT CHILDREN INFORMATION

11. Dependent children on Medi-Cal covered by health insurance (If more space is needed, complete another form.)

Child's Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth Month	Day	Year	County Code	Aid Code	Medi-Cal ID Number (Case Number)	F BU	Pers. No.

NONCUSTODIAL PARENT INFORMATION (ITEMS 12 THROUGH 19)

12. Name (first)	(middle)	(last)	13. Date of birth	14. Social Security number
15. Complete street address				
City	State	ZIP code		16. Home telephone number ( )
17. Name of employer				
18. Employer's complete street address				
City	State	ZIP code		19. Work telephone number ( )

HEALTH INSURANCE INFORMATION (ITEMS 20 THROUGH 23)

If additional insurance coverage (medical, dental, and/or vision) is being provided, please complete the back of this form

20. Health insurance is provided by (check appropriate box)

❒ Noncustodial parent ❒ Custodial parent ❒ Other If other, please state: _____ (Name) _____ (Relationship)

21. Name of insurance company or union	21a. Union Local number
22. Complete street address of insurance company or union (address where claims are mailed)	
City State ZIP code	23. Policy number

24. Type of Coverage: Does the health insurance provide or pay for: (Check *all* that apply, if information is available.)

❒ Hospital outpatient (i.e., lab work/physical therapy) ❒ Doctor visits ❒ Prescription drugs
❒ Hospital stays ❒ Long-term care/nursing home ❒ Dental care
❒ Vision care

ADDITIONAL HEALTH INSURANCE POLICY INFORMATION

DENTAL INSURANCE INFORMATION (Please complete if dental coverage is being provided)

1. Name of insurance company or union | 1a. Union Local number

2. Complete street address of insurance company or union (address where claims are mailed)

City | State | ZIP code | 3. Policy number

VISION INSURANCE INFORMATION (Please complete if vision coverage is being provided)

1. Name of insurance company or union | 1a. Union Local number

2. Complete street address of insurance company or union (address where claims are mailed)

City | State | ZIP code | 3. Policy number

MEDICAL INSURANCE INFORMATION (Please complete if additional medical coverage is being provided)

1. Name of insurance company or union | 1a. Union Local number

2. Complete street address of insurance company or union (address where claims are mailed)

City | State | ZIP code | 3. Policy number

REMARKS

IMPORTANT: All Medi-Cal eligibles must irrevocably assign the benefits of any contractual or legal entitlement for health care to the State Department of Health Services. Assignment of medical rights allows the Department of Health Services to code Medi-Cal cards and recover funds from insurance companies when the Medi-Cal program pays for medical services which could be billed to other health insurance plans. IN THE EVENT THAT YOUR PRIVATE HEALTH INSURANCE TERMINATES, NOTIFY YOUR COUNTY WELFARE DEPARTMENT.

INFORMATION COLLECTION AND ACCESS

Information concerning your health coverage is maintained by the Chief of the Recovery Branch, by authority of the Welfare and Institutions Code, Section 14011, and Title 22, California Code of Regulations (CCR), Section 50769. All information is mandatory. The information requested is necessary to effect utilization of health insurance or other contractual or legal entitlements as provided in Welfare and Institutions Code, Sections 10020 through 10025, 11490, 14024, 14103, and 14124.70, with persons liable thereunder. Please note that under the authority of Welfare and Institutions Code, Section 14100.2, and in order to comply with the Federal Privacy Act, Section 7(b), your Social Security number and all of the information you provide are used for identification in contacting insurance companies, providers of health care services, county agencies, or your legal counsel under the authority of Welfare and Institutions Code, Section 14102.

Sections 50761 and 50763 of Title 22, California Code of Regulations, require recipients to use and report other health coverage to which they are entitled. Additionally, Section 50175 of Title 22, provides for denial or discontinuance of benefits if the recipient does not cooperate in providing health insurance information.

Section 14023 of the Welfare and Institutions Code provides that any public assistance recipient who has any other contractual or legal entitlement to any health care service and who willfully refuses to disclose this information by withholding important information regarding other medical entitlement is guilty of a misdemeanor. ***MEDI-CAL IS THE PAYOR OF LAST RESORT.***